MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

05556

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County Montgomery
WITHIN CORPORATE LIMITS OF
City or town Takoma Park
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Washington Sanitarium and Hospital
Stay in hospital or inst. (yrs., or mos., or days) 13 days
Stay in this community (yrs., or mos., or days) 33 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Takoma Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 306 Elm Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Lillian Alsip

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ralph C. Alsip
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): November 26, 1897

8. AGE: Years 42 | Months 5 | Days 5 | If less than one day ____ hrs. ____ min.

9. Birthplace: Washington, D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: John A. Ridgeway
13. Birthplace: Silver Hill, Maryland

MOTHER
14. Maiden name: Lucille Plumbe
15. Birthplace: Suffolk, Virginia

16. Informant: Washington Sanitarium Records
Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1940 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln Cemetery
Location: Bladensburg, Md.

18. Funeral director: J. Arthur Walters
Address: 254 Carroll St. Takoma Park, D.C.

19. May 1 1940 (Date rec'd by registrar) J. Wilson Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1940, at 8:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1940, to May 1 1940, and that I last saw her alive on May 1 1940.

Immediate cause of death: Pelvic Peritonitis — DURATION: 6 days.

Due to following (Subtotal Hysterectomy)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: Fibroid Uterus.
Of autopsy: Pelvic Peritonitis.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: A. E. Coyne M.D. M. D. or other
Address: Takoma Park, Maryland Date signed: May 1, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

05557

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Dickerson R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 85 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....

City or town .....

(If outside city or town limits, write RURAL and give nearest town)

Street No. .....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Jacob Betters

3.(b) Social Security Number

4. Sex: Male

5. Color or race: Col

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Annie Betters

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. - 1855

8. AGE: Years: 85 ~~1855~~ | Months: Oct | Days: - | If less than one day ..... hrs. ..... min.

9. Birthplace: Martinsburg (Town, county, and state) W.Va.

10. Usual occupation: Martinsburg

11. Industry or business

FATHER

12. Name: Isaac Betters

13. Birthplace: Martinsburg

MOTHER

14. Maiden name: Nancy Jones

15. Birthplace: Martinsburg

16. Informant: Molly Betters

Address: Dickerson

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30 1940 (month) (day) (year)

Cemetery or crematory: Martinsburg

Location: Martinsburg near Dickerson

18. Funeral director: Clarence H Davis

Address: Poolesville

19. May 29 1940 (Date rec'd by registrar) E W White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1940 at about 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19 ..... to ..... 19 .....

and that I last saw ..... alive on ..... 19 .....

Immediate cause of death: Coronary Case

Probably coronary thrombosis due to Chronic myocarditis

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 8 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C E Hawks M. D. or other

Address: Poolesville Md Date signed: 3/29/40

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JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

05558

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 21 Quincy St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 15 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Mont.

City or town: Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 21 Quincy St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: non

3. (a) FULL NAME: HARRIET FRANCES BOYER

3. (b) Social Security Number: non

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: m

6 (b) Name of husband or wife: ~~Frederic~~ G. Boyer Eugene L.

6(c) If alive, give age ~~50~~ years

7. Birth date of deceased (mo., day, yr.): Aug 2 - 1855

8. AGE: Years: 84 Months: 9 Days: 12 If less than one day: hrs. min.

9. Birthplace: Norwalk Conn.
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business: none

FATHER
12. Name: Francis E. Quintard
13. Birthplace: Norwalk Conn

MOTHER
14. Maiden name: Matilda Lounsbury
15. Birthplace: N. Y. State.

16. Informant: Frederic G. Boyer
Address: 21 Quincy St.

17. (Burial, cremation, or removal. Which?) Date thereof: 5-14-40 (month) (day) (year)

Cemetery or crematory: Wash. D. C

Location:

18. Funeral director: Jos Gawler's Sons
Address: 1736 Pa Ave. Wash. D. C.

19. May 14 1940 (Date rec'd by registrar) Thomas X. Conrad Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1940, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1939 to May 14 1940, and that I last saw her alive on May 14 1940.

Immediate cause of death: Acute Left Ventricular Failure c̄ Pulmonary Edema

Due to: Hypertension Heart Disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no -

DURATION: 1 hour. years?

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Eric P. Campbell M. D. or other

Address: 3060 - 16th St. Date signed: 5/14/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05559

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 8800 Colesville Pike

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Six years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montg.

City or town Silver Spring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 8800 Colesville Pike
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Ernest Eckert Brown

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Sola Parker Brown

6(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) October 27, 1871

8. AGE: Years 68 | Months 6 | Days 4 | If less than one day ____ hrs. ____ min.

9. Birthplace Gary County, Indiana (Town, county, and state)

10. Usual occupation Commission Merchant (Retired)

11. Industry or business Live Stock.

FATHER 12. Name Peter Brown

13. Birthplace Indiana

MOTHER 14. Maiden name Cornelia Gary

15. Birthplace Indiana

16. Informant Mrs Sola Parker Brown

Address 8800 Colesville Pike Silver Spring Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 3, 1940 (month) (day) (year)

~~Cemetery or~~ crematory Fort Lincoln

Location Bladensburg Rd, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. May 2 1940 (Date rec'd by registrar) Dallie B. Leibig Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1940, at 7.05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 5 1934 to May 1 1940 and that I last saw him alive on April 30 1940.

	DURATION
Immediate cause of death Chronic Myocarditis	6 months
Due to Chronic Multiple Arthritis Deformans	10 years
Due to	
Other conditions Anaemia, Secondary to Chronic Arthritis (Include pregnancy within 3 months of death)	4 years

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Howlett, M.D.
M. D. or other

Address 928 Eliza Avenue Silver Spring Md. Date signed May 1, 1940

RECEIVED
MAY 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (30-a) Reg. Dist. No.

CERTIFICATE OF DEATH

05560

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town rural Clarksburg, Md.
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 25 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Maryland (b) County Montgomery
(c) City or town rural Clarksburg
(If outside city or town limits, write RURAL and give town)
(d) Street No. 1 mi. East Clarksburg, Md.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) **FULL NAME** Ethel May Brown

3 (b) If veteran, name war —
3 (c) Social Security No.

4. Sex Female
5. Color or race Colored
6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife —
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 29, 1911

8. **AGE:** Years 28 Months 11 Days 23 If less than one day — hr. — min.

9. Birthplace Hyattstown, Md.
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business Community homes

FATHER
12. Name William George Brown
13. Birthplace Germantown rural, Md.

MOTHER
14. Maiden Name Bessie May Jenkins
15. Birthplace Hyattstown, Md.

16 (a) Informant Joseph Mason
(b) Address Germantown, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory Rocky Hill
Location Rocky Hill Md.

18 (a) Funeral director Roy Barber
(b) Address Laytonsville, Md.

19 (a) May 23-40 (Date rec'd by registrar) (b) M. E. Lewis Local Registrar

MEDICAL CERTIFICATION

20. Date of death May 22 1940, at 4:00 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Nov. 7 1938, to May 22 1940, and that I last saw ~~him~~ her alive on May 22 1940.

Immediate cause of death	Duration
Acute myocarditis, luetic	4 days.
Due to syphilis	2 yrs. +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Geo. D. Selby, M. D.
M. D. or other
Address Dawsonville, Md Date signed 5-23-40

VS. A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05561

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 213

Village or City Rockville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Brunner

(a) Residence: No. Rockville St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	Col	Single

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year) Stillborn

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Rockville
(State or country)

FATHER

13. NAME unknown

14. BIRTHPLACE (city or town) "
(State or country)

MOTHER

15. MAIDEN NAME Virgie Brunner

16. BIRTHPLACE (city or town) Md
(State or country)

17. INFORMANT Lawrence Dufour
(Address) Rockville Md

18. BURIAL, CREMATION, OR REMOVAL
Place Rockville Md Date May 4, 1940

19. UNDERTAKER Lawrence Dufour
(Address) Rockville Md

20. FILED May 4, 1940 Faye Barnsley
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 4 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Stillborn, 19 to , 19

I last saw him alive on , 19 ; death is said to have occurred on the date stated above, at m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importence were as follows:

	Date of onset
Other **Contribntory Causes** of Importance:	

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) C. E. Hawkins M. D.

(Address) Rockville

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(40)

CERTIFICATE OF DEATH

05562

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery Co

City or town Chevy Chase Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
23 Primrose St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 15 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 23 Primrose St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME Henry Richard Bryarly

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife Elizabeth Bryarly

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 13, 1879

8. AGE:

Years	Months	Days	If less than one day
60	6	5	____ hrs. ____ min.

9. Birthplace Clarksville Texas
(Town, county, and state)

10. Usual occupation Insurance

11. Industry or business

FATHER 12. Name Roland T. Bryarly

13. Birthplace Virginia

MOTHER 14. Maiden name Hallie Baker

15. Birthplace Winchester Va.

16. Informant Mrs James M. K. Berry

Address 1336 30th St. NW.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 18 - 40 (month) (day) (year)

~~Cemetery or crematory~~ to D.C.

Location

18. Funeral director The S. H. Hines Co

Address 2901 14th St. NW.

Washington D.C.

19. May 18 - 1940 (Date rec'd by registrar) Thomas K. Conrad Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 9.30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov - 1939, to May 18 1940, and that I last saw h(im/er) alive on May 17 1940

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions Arteriosclerosis Hypertention. (Include pregnancy within 3 months of death)	
Major findings	
Of operations —	
Of autopsy	

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE T. Lyman Leyton M.D.
M. D. or other

Address 1801 Eye St NW Date signed May 18, 40

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JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

05563

CERTIFICATE OF DEATH

Reg. Dist. No. 216.

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 6117 Brookville Rd

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 6117 Brookville Rd
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR No service

3. (a) FULL NAME Carleton Ward Cameron

3. (b) Social Security Number NONE

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Anna C Cameron

6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.): July 8 1878

8. AGE: Years ~~62~~ 61 | Months 10 | Days 2 | If less than one day ____ hrs. ____ min.

9. Birthplace: Boston, Mass.
(Town, county, and state)

10. Usual occupation: U. S. Gov't. Employee (Retired)

11. Industry or business: "

FATHER
12. Name: Ewin Cameron
13. Birthplace: Prince Edward Island

MOTHER
14. Maiden name: L. Jane Mulhearn
15. Birthplace: Ireland

16. Informant: Anna C. Cameron

Address: 6117 Brookville Rd Ch. Ch. Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof 5-13-40 (month) (day) (year)

Cemetery or crematory: St John's Cemetery

Location: Forest Glen Md

18. Funeral director: Francis J Collins

Address: 3821-14 St. Nw. Wash. D.C.

19. May 11 — 1940 (Date rec'd by registrar) Thomas K Conrad Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 1 1937, to May 10 1940, and that I last saw him alive on May 10 1940.

Immediate cause of death: Coronary Thrombosis — DURATION: 10 days

Due to

Due to

Other conditions: Hypertension (Cerebral Hemorrhage 1932) — 8 yrs.
(Include pregnancy within 3 months of death)

Major findings:
Of operations ✓
Of autopsy ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE C. A. Lally MD M. D. or other

Address 3800 Cath Ave Nw Date signed 5/11/40

3800 Cath Ave

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 1 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

05564

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Forest Glen, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Forest Glen Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Eunice Fern Morton Cheeney

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 9, 1922

8. AGE: Years 18 | Months 0 | Days 0 | If less than one day ___ hrs. ___ min.

9. Birthplace Forest Glen, Md.
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name Wm. A. Cheeney
13. Birthplace Md.

MOTHER
14. Maiden name Louise M. J. Yeager
15. Birthplace Md.

16. Informant Wm. A. Cheeney
Address Forest Glen, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof May 11, 1940
(month) (day) (year)

Cemetery ~~or crematory~~ Rock Creek

Location Washington, D. C.

19. Funeral director Warner E. Pumphrey
Address Silver Spring, Md.

19. May 10 1940
(Date rec'd by registrar)
Sallie B. Leibig
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1940, at 1030 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Corona Case 19 ___, to ___ 19 ___, and that I last saw h ___ on ___ 19 ___.

Immediate cause of death Asphyxia due to epileptic seizure

Due to

Due to Epilepsy since birth

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Hawks M.D. of other OO
Deputy Med. Exam. of Mont.
Address Rockville Md. Date signed 5/9/40

JUN 7 1940
BUREAU V. S.

05565

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Monty

City or town Poolesville Rural

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still birth Clements

3. (b) Social Security Number

4. Sex Undetr

5. Color or race W

6. (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 20-40

8. AGE: Years 0 Months Days If less than one day hrs. 0 min.

9. Birthplace Poolesville (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Thomas Clements

13. Birthplace Barnsville

MOTHER 14. Maiden name Leona Waddel

15. Birthplace Chatham Hill Va

18. Informant Mrs Tom Clements

Address Poolesville

17. — (Burial, cremation, or removal. Which?) Date thereof — (month) (day) (year)

Cemetery or crematory —

Location —

18. Funeral director —

Address

19. June 2 1940 (Date rec'd by registrar) E.W. White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1940, at 9 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from no physician 19 to 19

and that I last saw h alive on 19

Immediate cause of death Mother Claims had spontaneous abortion

Due to

Due to I did not see her untill June 2-40

Other conditions (Premature birth, 2 mo. Gestation)

(Include pregnancy within 3 months of death)

DURATION

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE E.W. White M. D. or other

Address Poolesville Date signed 6/2/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05566

1. PLACE OF DEATH

County of Montgomery — Registration Dist. No. 223

WITHIN CORPORATE LIMITS OF

Village or City Takoma Park - Md. No. Washington Sanitarium St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of rasidance in city or town where deeth occurred 1 yrs. 11 mos. 14 ds. How long in U.S. if of foraign birth? yrs. mos. ds.

2. FULL NAME Concklin - Mrs Frances — If U. S. Veteran, specify WAR

(a) Residence: No. 1619 R St. N.W. Wash D.C St., Ward. Wash. D. C.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Fe.	American	widowed

5a. If married, widowad, or divorcad HUSBAND of (or) WIFE of Concklin - Mr Edward F.

6. DATE OF BIRTH (month, day, and yaar) July 12 - 1878

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	9	26	

OCCUPATION

8. Trada, profession, or perticuler kind of work done, as SPINNER, SAWYER, BOOKKEEPER, atc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, atc. Own Home

10. Date deceesed last worked et this occupation (month and year) May - 1938

11. Totel tima (years) spant in this occupation 28 yrs

12. BIRTHPLACE (city or town) Lees burg (State or country) Virginia

FATHER

13. NAME Marlow - Mr Edward G.

14. BIRTHPLACE (city or town) (Steta or country) Maryland

MOTHER

15. MAIDEN NAME Fox - Miss Anna

16. BIRTHPLACE (city or town) Lees burg (State or counlry) Virginia

17. INFORMANT Washington Sanitarium & Hosp. (Addrass) Takoma Park - Maryland

18. ~~BURIAL, CREMATION, OR REMOVAL~~ Place Wash D.C. Date 5 - 8, 1940

19. UNDERTAKER Jos Gawler's Sons (Addrass) 1356 Pa. Ave Wash D.C.

20. FILED May 8, 1940 [signature] Deputy Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 8 (Day), 1940 (Yaar)

22. I HEREBY CERTIFY, That I attanded decaased from Nov 14, 1939, to May 7, 1940

I last saw h ew elive on May 7, 1940; death is said to have occurrad on the date statad above, at 10 51 a. m.

The PRINCIPAL CAUSE OF DEATH and ralatad causes of importance were as follows: Peritonitis c̄ multiple abscesses. — Date of onset

Other Contributory Causes of importanca: Ca of Sigmoid

Name of operetion Mickulicz Date of Apr 28

What test confirmed diegnosls? Mikulicz's Wes thare en eutopsy?

23. If daeth wes due to external causes (VIOLENCE) fill in elso the following:

Accidant, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whather injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Wes disease or injury in eny way related to occupetion of decaasad? No

If so, specify

(Signad) [signature] M. D.

(Address) Takoma Park

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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JUN 5 1940
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

STATE OF MARYLAND—CERTIFICATE OF DEATH

05567

48-C

1. PLACE OF DEATH

County of Montgomery — Registration Dist. No. 223-

WITHIN CORPORATE LIMITS OF

Village or City Takoma Park Md. — No. Washington San. + Hosp. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S. if of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Cyphers — Mrs Sue B. — If U. S. Veteran, specify WAR ____

(a) Residence: No. 129 Chestnut Ave. St., Ward. Takoma Park - Md.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe.

4. COLOR OR RACE: American

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Cyphers - Mr Russell S.

6. DATE OF BIRTH (month, day, end yeer): April 27 - 1878

7. AGE: Years 62 — Months 0 — Days 26 — If LESS than 1 day, ____ hrs. or ____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BODKKEEPER, etc.: Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Own Home

10. Date deceased last worked at this occupation (month and year): March - 1940

11. Total time (years) spent in this occupation: 35 yrs.

12. BIRTHPLACE (city or town) (State or country): Monroe County Pennsylvania

FATHER

13. NAME: Bittenbender - Aaron

14. BIRTHPLACE (city or town) (State or country): Monroe County Pennsylvania

MOTHER

15. MAIDEN NAME: Fenner, Elmira — Jenner, Almira

16. BIRTHPLACE (city or town) (State or country): Monroe County Pennsylvania

17. INFORMANT (Address): Washington Sanitarium & Hosp. Takoma Park - Md.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Cem.

Place: Warl. Mem. Park Date: May 25, 1940

19. UNDERTAKER (Address): Warner E. Pumphrey Silver Spring, Md.

20. FILED: 5/24, 1940 — J. J. Allen Dodd, Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH: May (Month) 23 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 8, 1940, to May 23, 1940

I last saw her alive on May 23, 1940; death is said to have occurred on the date stated above, at 8 12 p. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Carcinoma of Uterus	1935
Metasis to the	/
Lungs	1939
Cervical Spinal Cord	1939

Other Contributory Causes of importance:

1937

Name of operation: Hysterectomy — Date of 1938

What test confirmed diagnosis? Biopsy — Was there an autopsy? Yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ____ Date of injury ____, 19____

Where did injury occur? ____ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ____

Nature of injury ____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify ____

(Signed) George M. Gibbs M. D.

(Address) Takoma Park Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED JUN 5 1940 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Authorization to make corrections, letter in Permanent File under Dr. G. M. Gibbs 7-2-40. C.

05568

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 836 Noyes Drive

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montg.

City or town Silver Spring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 836 Noyes Drive
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura L. Eckloff

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Widow

6 (b) Name of husband ~~or wife~~ Randolph J. Eckloff

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 9, 1862

8. AGE: Years 78 Months 0 Days 3 If less than one day hrs. min.

9. Birthplace D.C.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name John G. Judd
13. Birthplace England

MOTHER
14. Maiden name Suzanna Elelent
15. Birthplace England

16. Informant Mrs. Herbert Peddicord

Address 836 Noyes Drive, Silver Spring

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof May 14, 1940
(month day) (year)

Cemetery ~~or crematory~~ Rock Creek

Location Washington, D.C.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. May 13 1940
(Date rec'd by registrar)

Sallie B. Leibig
Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1940, at 2.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Coroner 19 , to 19 ,
and that I last saw h alive on Case 19

Immediate cause of death Coronary Thrombosis
Advanced Arterio Sclerosis

Due to Chronic Myocarditis

Due to

Other conditions Senility

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Hawk M.D.
Deputy med Exy Mont Co
M. D. or other

Address Rockville Md Date signed 5/12/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 16 1940
BUREAU V. S.

05569

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:

County Mongomery

City or town Washington Grove
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1 Chestnut End Oak Sts.

Stay in hospital or inst. (yrs., or mos., or days) none

Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Washington Grove Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1 Chestnut End Oak Sts
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Damaris Fennell

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 10, 1937

8. AGE: Years 2 Months 9 Days 1 If less than one day hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation none

11. Industry or business —

FATHER
12. Name Anthony B. Fennell
13. Birthplace North Carolina

MOTHER
14. Maiden name Madeline Fennell
15. Birthplace Cambridge, Mass.

16. Informant Grandmother Alice M. O'Brien
Address Washington Grove, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14/40 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Washington D.C.

18. Funeral director D. C. Farhin

Address Gaithersburg Md.

19. May 13 1940 (Date rec'd by registrar) Alseda G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1940, at 3 45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7 1940, to May 11 1940, and that I last saw her alive on May 11 1940.

Immediate cause of death Broncho-pneumonia — DURATION 2 days

Due to

Due to

Other conditions Endocarditis — 2.

(Include pregnancy within 3 months of death)

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Please underline tha causa to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul A. Taylor M.D. M. D. or other

Address 2140 Penna. Ave. Wash. D.C. Date signed 5-11-40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05570

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town County Home
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 6½ years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town County Home Clarksburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rockville
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Charles M Gibson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary L Gibson

6(c) If alive, give age [redacted] years

7. Birth date of deceased (mo., day, yr.) Jan. 28 - 1860

8. AGE: Years	Months	Days	If less than one day
80	3	—	hrs. min.

9. Birthplace Clarksburg Md
(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

FATHER 12. Name John H Gibson

13. Birthplace Lafayette Co - Mo

MOTHER 14. Maiden name Lucinda Trumbley

15. Birthplace Clarksburg Md

18. Informant Mrs Beall

Address County Home

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-10-1940 (month) (day) (year)

Cemetery or crematory Clarksburg Md

Location Maryland

18. Funeral director Hilton & Burdette

Address Wyattsville Md

19. May 8 1940 (Date rec'd by registrar) Faye Ramsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1940 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1940, to May 8 1940, and that I last saw him alive on May 7 1940

Immediate cause of death Lobar Pneumonia — DURATION 4 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. V. Hartley, M.D. M. D. or other

Address Rockville Date signed May 8, 1940

RECEIVED
JUN 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-a)

Reg. Dist. No. 216

05571

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Montgomery

(b) City or town 136 Leland St., Chevy Chase, Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 4 Yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Maryland (b) County Montgomery

(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)

(d) Street No. 136 Leland Street
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Adelia Giddings

3 (b) If veteran, name war	3 (c) Social Security No.
None	None

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Widowed

6 (b) Name of husband or wife Alfred Giddings

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 17, 1855

8. AGE: Years	Months	Days	If less than one day
85	11	22	_____hr. _____min.

9. Birthplace Washington, D.C.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name James Burdine

13. Birthplace Washington, D.C.

MOTHER

14. Maiden Name Emma F. Shekell

15. Birthplace Washington, D.C.

16 (a) Informant Miss Pearl Burdine

(b) Address 136 Leland St., Chevy Chase, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 11, 1940 (month) (day) (year)

(c) Cemetery or crematory Congressional Cemetery

Location Washington, D.C.

18 (a) Funeral director Wm. Reuben Pumphrey

(b) Address 7005 Wisconsin Ave., Bethesda, Md.

19 (a) 5-10-40 (Date rec'd by registrar) (b) B.C. Perry / Registrar

MEDICAL CERTIFICATION

20. Date of death May 9 1940, at 7:30 AM

21. I certify that death occurred on the date above stated; that I attended deceased from About 2 years 19__, to _____ 19__, and that I last saw him alive on Apr. 4th 1940.

Immediate cause of death	Duration
Condition	decompensation
Due to	Aortic regurgitation
Due to	Cardio renal vascular
Other conditions	Hypertension

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature J. Lawn Thompson M.D. (M. D. or other)

Address 5-10-'40 Date signed

1735 20th, N.W., Wash, D.C.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-8)

CERTIFICATE OF DEATH

05572

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Olney

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Montg. Co. Gen. Hospital

Stay in hospital or inst. (yrs., or mos., or days) about 4 days.

Stay in this community (yrs., or mos., or days) 18 yrs - in Rockville

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 525 - W. Montg Ave

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME J. Harry Gormley

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6 (b) Name of husband or wife Everetta Elizabeth Gormley

6(c) If alive, give age about 30 years

7. Birth date of deceased (mo., day, yr.) February 13 - 1901

8. AGE:

Years	Months	Days	If less than one day
39	2	23	hrs. ____ min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Real Estate.

11. Industry or business Own Business

FATHER 12. Name Philip F. Gormley

13. Birthplace Washington D.C.

MOTHER 14. Maiden name Maud L. Edwards

15. Birthplace Washington D.C.

16. Informant Mrs. J. H. Gormley

Address 525 - W. Montg Ave Rockville

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8 - 1940 (month) (day) (year)

Cemetery or crematory St. Marys - Catholic

Location Dear Rockville Maryland

18. Funeral director Wm. Reuben Pumphrey

Address Rockville Maryland

19. May 7 1940 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1940, at 5.30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h alive on ____ 19__.

Immediate cause of death	DURATION
Coroners Case	
Vagus nerve Paralysis	
due to hypodermic	
Poison	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 5/6/40

Where did injury occur? Rockville (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Poison Injured at work? No

23. SIGNATURE E. E. Hawks M.D.
Coroner

Address Rockville Md Date signed 5/6/40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (20)

05573

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery Co. Gen. Hospital

City or town Olney, Maryland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: The Montg. Co. General Hospital

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg, Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura Grogg

3. (b) Social Security Number

4. Sex: female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Widowed

6(b) Name of husband or wife: unknown

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 8, 1909

8. AGE: Years 30 | Months 9 | Days 12 | If less than one day ____ hrs. ____ min.

9. Birthplace Chatam Virginia (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER

12. Name Wilson

13. Birthplace Chatam, Va.

MOTHER

14. Maiden name American Poston

15. Birthplace McCurty, Va.

16. Informant Hospital Records.

Address

17. Burial. (Burial, cremation, or removal, Which?) Date thereof May 22/40 (month) (day) (year)

Cemetery or crematory Chilhowie Va.

Location near Marion Va.

18. Funeral director Lynch Co. Gaithers

Address Gaithersburg Md.

19. May 21 1940 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1940, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 1940, to May 21 1940, and that I last saw her alive on May 21 1940.

Immediate cause of death Septicaemia — DURATION 12 days

Due to Bilateral Tuberculosis — 12 mos

Due to Pyelitis

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations None.

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury None Injured at work? No

23. SIGNATURE J. M. B. M. D. or other

Address Sandy Spring Md. Date signed 5/20/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (57B)

CERTIFICATE OF DEATH

05574

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

WITHIN CORPORATE LIMITS OF

City or town Takoma Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 124 Flower Ave.,

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 124 Flower Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Peter C. Hanson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6 (b) Name of husband or wife Emily Hanson

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 29, 1851

8. AGE: Years	Months	Days	If less than one day
88	2		hrs. min.

9. Birthplace Falster, Denmark (Town, county, and state)

10. Usual occupation Merchant - Retired

11. Industry or business

FATHER 12. Name Cornelius Hanson

13. Birthplace Denmark

MOTHER 14. Maiden name Kirstein Jergenson

15. Birthplace Denmark

16. Informant Wash. San. & Hosp - records

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 12, 1940. (month) (day) (year)

Cemetery or crematory

Location Knapp, Wisconsin.

18. Funeral director J. Arthur Dalton

Address 254 Carroll St. Takoma Park D.C.

19. May 9 1940 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 19 40, at 6:38 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 40 to May 8 19 40

and that I last saw her alive on May 8 19 40

Immediate cause of death	DURATION
Cancer of Prostate	?
Due to Myocardial Weakness	7 mos
Due to Old Fracture	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations Operated at Mercy Hosp for Ca of Prostate

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas H. Holohan M.D

M. D. or other

Address Takoma Park, Md. Date signed 5/7/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-e)

05575

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Near Cornus, Dickerson, R.F.D.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 7 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State County

City or town Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William W. Hessie

3. (b) Social Security Number None

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Rosie E. Hessie

6(c) If alive, give age 66 years

7. Birth date of deceased (mo., day, yr.) Feb 13 · 1864

8. AGE: Years 75 | Months 3 | Days 0 | If less than one day ___ hrs. ___ min.

9. Birthplace Annapolis, Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name William Hessie
13. Birthplace Unknown

MOTHER
14. Maiden name Sarah Sellman
15. Birthplace Unknown

16. Informant Rosie Hessie
Address Barnesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/40 (month) (day) (year)

Cemetery or crematory Mt View

Location Lewisdale

18. Funeral director William B. Hilton
Address Barnesville, Md.

19. 5/15/40 (Date rec'd by registrar) 19 Mrs C.C. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May - 13 - 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 7 - 1940, to May - 13 - 1940, and that I last saw him alive on May - 13 - 1940.

Immediate cause of death: Myocardial insufficiency — DURATION 4 years

Due to Senility

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Miller, M.D.
M.D. or other

Address Gaithersburg, Md. Date signed 5/15/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05576

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: 800 Richmond Avenue

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Three years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Penn. County

City or town Ambler Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Amelia Adelaide Hocker

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Martin P. Hocker

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 5, 1861

8. AGE: Years	Months	Days	If less than one day
79	1	—	hrs. min.

9. Birthplace Union Deposit, Pennsylvania (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name Joseph Tarnsler

13. Birthplace Pennsylvania

MOTHER 14. Maiden name Elizabeth Marks

15. Birthplace Pennsylvania.

16. Informant Mrs. L. E. Nesbit

Address 800 Richmond Ave. Silver Spring

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1940. (month) (day) (year)

Cemetery or crematory Upper Dublin Lutheran Cemetery

Location Ambler, Penna.

18. Funeral director J. Arthur Walters

Address 254 Carroll St. Takoma Park, D.C.

19. May 6 1940 (Date rec'd by registrar) Sallie B. Leibig Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1940, at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1940, to May 5 1940, and that I last saw h alive on May 5 1940.

	DURATION
Immediate cause of death Coronary Occlusion	2 days
Due to Arteriosclerosis	10 years
Due to	
Other conditions Secondary Anaemia	2 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Hovelett M. D. M. D. or other

Address 928 Sligo avenue, Silver Spring, Md. Date signed May 5, 1940.

RECEIVED
JUN 7 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (114d)

05577

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery county Md.

City or town Silver springs Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 9011-1st. ave.

Stay in hospital or inst. (yrs., or mos., or days) — —

Stay in this community (yrs., ~~or mos., or days~~) 15 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery co.

City or town Silver spr. Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 9011-1st ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Bernice Torrence Johnson

3. (b) Social Security Number: none.

4. Sex: female ~~white~~

5. Color or race: White

6. (a) ~~Single, married~~, widowed, ~~or divorced~~: widowed

6 (b) Name of husband ~~or wife~~: Wellington B. Johnson

Deceased

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Jan. 7th 1883.

8. AGE: Years 57 | Months 4 | Days 10 | If less than one day ___ hrs. ___ min.

9. Birthplace: Wapinquatin Nebraska. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Barnum S. Torrence

13. Birthplace: N.Y. State

MOTHER

14. Maiden name: Harriet A Smith

15. Birthplace: N.Y. State

16. Informant: Mrs. Murphy

Address: 9011-1st. ave. Silver sp. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1940 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Rockville

18. Funeral director: The S. H. Hines co

Address: 2901-14th St. N.W. Wash. D.C.

19. 5/17 1940 (Date rec'd by registrar) Sallie B. Leibig Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1940, at 9 26 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death: Pulmonary Hemorrhage: due to erosion of blood-vessel. cw&R.

DURATION: 5 minutes

Due to Lung Abscess Right lower lobe: duration: two years

1½ yrs

Due to This patient did not have tuberculosis.

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations: Operated 1 yr ago. Bronchoscopic Drainage

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ___ Date of ___

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ___ Injured at work?

23. SIGNATURE: Kenneth Laughlin MD M. D. or other

Address: 8252 Georgia Ave Date signed 5/17/40

RECEIVED
JUN 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05578

170-C

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Rockville, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Norbeck Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ramon E. Johnson Sr.

3. (b) Social Security Number 214-03-8201

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 27, 1920

8. AGE:

Years	Months	Days	If less than one day
19	10	7	hrs. min.

9. Birthplace Garrett Park.

(Town, county, and state)

10. Usual occupation Mechanic Helper.

11. Indusfry or business

FATHER 12. Name Ramon E. Johnson.

13. Birthplace Norbeck, Md.

MOTHER 14. Maiden name Sadie E. Brown.

15. Birthplace Mt. Zion, Md.

16. Informant Sadie E. Johnson.

Address Norbeck, Md.

17. Buried Date thereof May 7, 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Norbeck

Location Norbeck, Md.

18. Funeral director Robert L. Snowden

Address Rockville, Md.

19. May 6 1940 Faye Barnsley

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1940, at 8:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Coroner Case 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death	DURATION
Fracture of Skull & right Mastoid bone	
Due to Hemorrhage	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/4/40

Where did injury occur? Mr. Rockville Montgomery Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Auto accident Injured at work? No

23. SIGNATURE A. E. Hawks M. D. or other

Address Rockville Md Date signed 5/6/40

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JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

05579

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Luther Jordan

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 12. 1901

8. AGE: Years: 39 | Months: 1 | Days: | If less than one day: hrs. min.

9. Birthplace: Ga. (Town, county, and state)

10. Usual occupation: Barber

11. Industry or business:

FATHER — 12. Name: James Jordan
13. Birthplace: Ga.

MOTHER — 14. Maiden name: Mary
15. Birthplace: Ga

16. Informant: Ruby Chandler
Address: 918 S. Scott St. Arlington Va.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 15, 1940 (month) (day) (year)

Cemetery or crematory: Haiti
Location: Rockville, Md.

18. Funeral director: Robert L. Snowden
Address: Rockville, Md.

19. 5-14 1940 (Date rec'd by registrar) Faye Lamsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940 at 6:18A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
March 7 1939, to 1940
and that I last saw him alive on May. 7, 1940

Immediate cause of death	DURATION
Congestive heart failure	6 months
Due to: Aortic Regurgitation	14 yr.
Due to: Syphilis	10 yrs plus
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. W. Welch M. D. (M. D. or other)
Address: Rockville Date signed: May 13, 1940

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 4 1940
U. S.

05589

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 218

1. PLACE OF DEATH:
County Montgomery
City or town Near Garden Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Twenty three

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Mt Laytonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Vernon D Kemp

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 4 - 1917

8. AGE: Years 23 Months — Days 2 If less than one day ___ hrs. ___ min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Farm

FATHER
12. Name Jonathan S Kemp
13. Birthplace Montgomery Co Md

MOTHER
14. Maiden name Mattie Curtis Kemp
15. Birthplace Montgomery Co Md

16. Informant Mrs Mattie Kemp
Address Gaithersburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8 1940 (month) (day) (year)
Cemetery or ~~crematory~~ Laytonsville Md
Location Montgomery Co Md

18. Funeral director Roy W Barber
Address Laytonsville Md

19. 5/7 1940 (Date rec'd by registrar) L. D Bell Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1940, at 1:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1939, to May 6 1940, and that I last saw him alive on May 5 1940.

Immediate cause of death Carcinoma of Descending Colon — DURATION unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George M. Boyer MD M. D. ~~or other~~
Address Damascus, Md Date signed 5-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

05581

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Forest Glen, Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.

City or town Forest Glen Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. —

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henrietta Phillips Keys

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband ~~or wife~~ Charles B. Keys

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 21, 1873

8. AGE: Years	Months	Days	If less than one day
66	9	19	hrs. min.

9. Birthplace Phila., Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name Charles Phillips

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Charles B. Keys

Address Forest Glen, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 13, 1940 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Crematory

Location Bladensburg Rd. P.G. Co. Md.

18. Funeral director Warner C. Pumphrey

Address Silver Spring, Md.

19. 5/13/40 (Date rec'd by registrar) 19 Sallie B. Leibig Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1934, to May 10 1940 and that I last saw he alive on May 10 1940.

	DURATION
Immediate cause of death Cerebral Hemorrhage	One hour
Due to Arteriosclerosis with hypertension	6 years
Due to	
Other conditions Chronic Myocarditis	4 years

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Howlett M.D. M. D. or other

Address 928 Sligo Ave. Date signed May 10, 1940

Silver Spring, Md.

JUN 7 1940
U. S.

05582

STATE OF MARYLAND—CERTIFICATE OF DEATH

CP

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 223

WITHIN CORPORATE LIMITS OF

Village or City Takoma Park No. Washington Sanitarium & Hospital St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S. If of foreign birth? ..... yrs. ..... mos. ..... ds.

2. FULL NAME Mr. Chancelor F. King If U. S. Veteran, specify WAR .....

(a) Residence: No. 1301 Prince Edward St St., ... Ward. Fredricksburg, Virginia

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) May 15, 1869

7. AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	11	22	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Storekeeper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Hardware

10. Date deceased last worked at this occupation (month and year) April 8, 1940

11. Total time (years) spent in this occupation 16 yrs

12. BIRTHPLACE (city or town) Fredricksburg (State or country) Virginia

FATHER

13. NAME Mr George King

14. BIRTHPLACE (city or town) ? Pennsylvania (State or country)

MOTHER

15. MAIDEN NAME Anna Chancelor

16. BIRTHPLACE (city or town) ? Virginia (State or country)

17. INFORMANT Washington Sanitarium Records (Address) Takoma Park Md.

18. BURIAL, CREMATION, OR REMOVAL Fredricksburg Va. Date May 8, 1940

19. UNDERTAKER Wheeler Thompson (Address) Fredricksburg Va.

20. FILED May 6, 1940 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 6 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 16, 1940, to May 6, 1940

I last saw him alive on May 5, 1940; death is said to have occurred on the date stated above, at 6 20 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Arteriosclerotic Heart Disease	2 years ago

Other Contributary Causes of Importance:

Name of operation None Date of ——

What test confirmed diagnosis? E.K.G. Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ..... Date of injury ....., 19....

Where did injury occur? ..... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury .....

Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify .....

(Signed) Henry E. Andrews, M. D.

(Address) Washington San & Hosp. Takoma Pk, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

RECEIVED JUN 5 1940 BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

05583

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (110)(a)

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

WITHIN CORPORATE LIMITS OF

City or town Takoma Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Sanitarium & Hospital

Stay in hospital or inst. (yrs., or mos., or days) 32 days

Stay in this community (yrs., or mos., or days) 32 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Gaithersburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frederick W. Kuster

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	W	Married

6 (b) Name of husband or wife Florence Kuster

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 4, 1863

8. AGE:

Years	Months	Days	If less than one day
77	1	10	hrs. min.

9. Birthplace Frederick Co., Maryland (Town, county, and state)

10. Usual occupation Miner

11. Industry or business ?

FATHER

12. Name Frederick W. Kuster

13. Birthplace Pennsylvania

MOTHER

14. Maiden name ? Dox

15. Birthplace Pennsylvania

16. Informant Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14/40 (month) (day) (year)

Cemetery or crematory

Location Boyd, Md.

18. Funeral director Wm. Reuben Humphrey

Address Bethesda — Md.

19. May 14 1940 (Date rec'd by registrar) J. Wilson Reed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14th 1940, at 1:56 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 19 1940 to May 14 1940, and that I last saw him alive on May 14 1940.

Immediate cause of death Subacute Nephritis ? DURATION

Due to Empyema of left chest due to pneumococcus 3 wks

Due to

Other conditions Myocardial failure terminal

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy See above

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 0

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. H. Wolohan M. D. or other

Address Takoma Park Md Date signed 5/14/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

05584

STATE OF MARYLAND—CERTIFICATE OF DEATH

83a

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 216

Village or City Bethesda No. 4640 Watkins ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ludwell L. Lee If U. S. Veteran, specify WAR

(a) Residence: No. 4640 Watkins ave St., Ward Social Security No. 578-05-7800 (Poss.)

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Goldie A. Lee

6. DATE OF BIRTH (month, day, and year) Nov. 10.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	15	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Gas Station Operator

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Virginia

FATHER

13. NAME Ludwell L. Lee

14. BIRTHPLACE (city or town) (State or country) Virginia

MOTHER

15. MAIDEN NAME Elizabeth Brown

16. BIRTHPLACE (city or town) (State or country) Virginia

17. INFORMANT Mrs Goldie A. Lee

(Address) 4640 Watkins ave

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Ivy Hill, Uppersville, Va Date May 27, 1940

19. UNDERTAKER Warner E. Pumphrey

(Address) 8424 Ga ave, Silver Spring, Md.

20. FILED May 25, 1940 B. C. Perry, M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 25 (Day), 1940 (Year)

22. I HEREBY CERTIFY That I attended deceased from May 18, 1940, to May 25, 1940

I last saw him alive on May 24, 1940; death is said to have occurred on the date stated above, at 2.35 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Apoplexy	May 12

Other Contributory Causes of Importance: Hypertension

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? N.

If so, specify

(Signed) Lee I. Donovan M. D.

(Address) 416 Georgetown Road

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (49-a)

05585

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town 6921 Fairfax Road, Bethesda, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda, Maryland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 6921 Fairfax Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Eleanora LeHuray Lewis

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife James Lewis
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) October 4, 1861

8. AGE: Years	Months	Days	If less than one day
79	7	20	____ hrs. ____ min.

9. Birthplace Trenton, New Jersey
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Charles Silver
13. Birthplace Philadelphia, Pennsylvania

MOTHER
14. Maiden name Elizabeth LeHuray
15. Birthplace Pennsylvania

16. Informant Mrs. Winifred Broocks
Address 6921 Fairfax Rd., Bethesda, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 25, 1940 (month) (day) (year)
Cemetery or crematory Fort Lincoln Crematory
Location Bladensburg Road, Maryland

18. Funeral director W Reuben Pumphrey
Address 7005 Wis Ave Bethesda Md

19. May 25 1940 (Date rec'd by registrar) B. C. Perry M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1940, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20 1929, to May 24 1940, and that I last saw h ____ alive on May 23 1940.

Immediate cause of death Alveo carcinoma ovarian with peritoneal metastases. — DURATION 8/12.

Due to

Due to

Other conditions Hypertensive heart disease with coronary sclerosis. — 12 yrs.
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Louis S Selcer M.D. M. D. or other
Address 1725 N St. N.W. Date signed 5/24/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05586

Reg. Dist. No. 217

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Montg Co Gen Hosp.

Stay in hospital or inst. (yrs., or mos., or days): 1 day.

Stay in this community (yrs., or mos., or days): Life.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Highland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Hubert Sucas.

3. (b) Social Security Number:

4. Sex: M.

5. Color or race: W.

6. (a) Single, married, widowed, or divorced: Mary.

B (b) Name of husband or wife: Sulu Johnson Sucas

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 2/27, 1885

8. AGE: Years 55 | Months 3 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business

FATHER
12. Name: John Sucas
13. Birthplace: Md

MOTHER
14. Maiden name: Ella Johnson
15. Birthplace: Md

16. Informant: Sulu Sucas.

Address: Highland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10th 40 (month) (day) (year)

Cemetery or crematory: Mt Zion

Location: Highland

18. Funeral director: Lloyd Carver

Address: Laurel Md.

19. May 7 1940 (Date rec'd by registrar) Gertrude B Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~6/~~ 5/6/ 1940, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/1/ 1940, to 5/6/ 1940, and that I last saw him alive on 5/6/ 1940.

Immediate cause of death: acute cardiac dilatation — DURATION: 1 day

Due to: Chronic Asthma with bronchitis — 2 yrs

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Not oper.

Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work? —

23. SIGNATURE: J M Bird M. D. or other

Address: Sandy Spring Md Date signed: 5/6/40

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VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

05587

CERTIFICATE OF DEATH

Reg. Dist. No. 211

1. PLACE OF DEATH:

County Montgomery

City or town nr. Cedar Grove

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Monty

City or town ~~nr~~ Rural Cedar Grove Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME 5-Mo. Foetus - not named Lyles

3. (b) Social Security Number none

4. Sex F.

5. Color or race C

6.(a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife —

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1940

8. AGE: Years Still-born | Months | Days | If less than one day hrs. min.

9. Birthplace nr. Cedar Grove, Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name John F. Lyles

13. Birthplace Damascus Md.

MOTHER

14. Maiden name Helena Genus

15. Birthplace nr. Cedar Grove, Md

16. Informant John F. Lyles

Address R.D. Germantown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 40 (month) (day) (year)

Cemetery or crematory Home garden

Location nr. Cedar Grove, Md

18. Funeral director J. B. Beall, Inc.

Address Damascus, Md.

19. May 20 1940 (Date rec'd by registrar) Della W. Burdette Dept. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 9 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1940, to 5 Mo. Foetus 19

and that I last saw her ~~alive~~ dead on May 18 1940

Immediate cause of death Unknown to me Premature birth

Due to ? (Wass. Neg.)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Boyer M. D. or other

Address Damascus, Md. Date signed 5-21-40.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-P)

05588

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Md
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Montg. Co. Emil Hospital

Stay in hospital or insf. (yrs., or mos., or days) 19 days

Stay in this community (yrs., or mos., or days) 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State ____ County ____

City or town 2322 Ashmead Place, N.W. Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Washington, D.C.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ____

3. (a) FULL NAME Minnie Mandrill

3. (b) Social Security Number ____

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

(b) Name of husband or wife ____

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) August 15, 1890

8. AGE:

Years	Months	Days	If less than one day
49	8	15	____ hrs. ____ min.

9. Birthplace Denton, Maryland
(Town, county, and state)

10. Usual occupation Maid

11. Industry or business Home

FATHER 12. Name Frederick Mandrill

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace ____

16. Informant Hospital Records

Address ____

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1940 (month) (day) (year)

Cemetery or crematory Colston

Location Colston, Md.

18. Funeral director Warner E. Pumphrey

Address Silver Spring, Md.

19. May 2 1940 (Date rec'd by registrar) Gertrude B. Lawton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH April May 1, 1940, at 11:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1940, to May 1 1940, and that I last saw her alive on May 1 1940.

	DURATION
Immediate cause of death: Uremia	1 week
Due to Chronic interstitial Nephritis	2 years
Due to ____	
Other conditions ____	

(Include pregnancy within 3 months of death)

Major findings:

Of operations ____

Of autopsy ____

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE J. M. Bell M. D. or other

Address Sandy Spring, Md. Date signed 5/1/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

05589

CERTIFICATE OF DEATH

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Clifton Park - Silver Spring

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 mo. 22 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring, Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Clifton Park

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Loretta Jane Merrell

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Charles Alfred Merrell 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 13, 1854

8. AGE: Years	Months	Days	If less than one day
86	1	10	hrs. min.

9. Birthplace New Hartford, Conn

(Town, county, and state)

10. Usual occupation Nones

11. Industry or business

FATHER 12. Name Stephen O. Mason

13. Birthplace Conn.

MOTHER 14. Maiden name Barney

15. Birthplace New Hartford, Conn.

16. Informant Mrs. Alfred J. Merrell

Address Clifton Park - Silver Spring, Md.

17. (Burial, cremation, or removal. Which?) Date thereof May 24, 40 (month) (day) (year)

Cemetery or crematory Fort Lincoln

Location

18. Funeral director Harford Dunphrey

Address Silver Spring Md.

19. May 24 1940 (Date rec'd by registrar) Sallie B. Leibig Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1940, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1940, to May 23 1940, and that I last saw h- alive on May 22 1940

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to	
Due to	
Other conditions Pleurisy Asthmatic Bronchitis	-
(Include pregnancy within 3 months of death)	-

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Marion Bankhead M.D. M. D. or other

Address Silver Spring, Md Date signed 5/23/40

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JUN 7 1940
U. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05590

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH (97)

County Montgomery — Registration Dist. No. 223

Village or City Takoma Park — No. 1114 Flower Ave. — St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 0 yrs. 2 mos. — ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

2. FULL NAME Senora Jane Meyers

(a) Residence: No. — St., Ward. Flintstone, Md

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F	W	widowed

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of Frederick C. Meyers

6. DATE OF BIRTH (month, day, and year) July 25, 1856

7. AGE — Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
83	10	6	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) Jan. 1940

11. Total time (years) spent in this occupation Life

12. BIRTHPLACE (city or town) (State or country) Altoona, Pennsylvania

FATHER

13. NAME Oliver Perry Nelson

14. BIRTHPLACE (city or town) (State or country) U.S.A.

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT Mrs. Marian Curtis — daughter

(Address) 1114 Flower Ave., Takoma Park

18. BURIAL, CREMATION, OR REMOVAL

Place Flintstone Date June 2, 1940

19. UNDERTAKER Jacob Baker

(Address) Cumberland

20. FILED May 31st, 1940 J. Hilton Dodd

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 31 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 12, 1940, to May 31, 1940

I last saw her alive on May 29, 1940; death is said to have occurred on the date stated above, at 3:15 P.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset (month, day, year)
Cerebral Arteriosclerosis	
Hypertension	

Other **Contributory Causes** of importance:

Name of operation none — Date of —

What test confirmed diagnosis? Clinical — Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? — Date of Injury —, 19—

Where did injury occur? (Specify city or town, county and State)

Specify whether Injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Robert A. Hare, M. D.

(Address) Takoma Park, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (61) CP Reg. Dist. No. 216 05591

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Montgomery
(b) City or town Chevy Chase (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 102 - Spring St.
(d) Length of stay in hospital or inst. (yrs., mos., or days) none
(e) Length of stay in this community (yrs., mos., or days) 11 days

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington (If outside city or town limits, write RURAL and give town)
(d) Street No. 717 - 9th, N.E. (If rural give location)
(e) If foreign born, how long in U. S. A.? ✓ years

3 (a) **FULL NAME** ANNIE ARANA NEVITT

3 (b) If veteran, name war ✓
3 (c) Social Security No. ✓

4. Sex F
5. Color or race W
6 (a) Single, married, widowed, or divorced. WIDOWED
6 (b) Name of husband or ~~wife~~ ROBERT I. NEVITT.
6. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) 1/16/1866

8. AGE: Years 74 | Months 4 | Days — | If less than one day — hr. — min.

9. Birthplace Washington, D.C. (Town, county, and state)
10. Usual occupation Retired School Teacher
11. Industry or business ✓

FATHER
12. Name Peyton Scrivener
13. Birthplace Washington, D.C.

MOTHER
14. Maiden Name Mary C. Gartrell
15. Birthplace Buckeystown, Md.

16 (a) Informant Son & Daughter
(b) Address 102 - Spring St.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-16-40 (month) (day) (year)
(c) Cemetery or crematory Washington D.C.
Location

18 (a) Funeral director Deal Funeral Home
(b) Address 4812 Ga. Ave. N.W. Wash. D.C.

19 (a) May 16 1940 (Date rec'd by registrar) (b) R. C. Perry Registrar

MEDICAL CERTIFICATION

20. Date of death May 16 1940 at 2: P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 5/6 1940 to 5/16 1940 and that I last saw him alive on 5/15 1940.

Immediate cause of death	Duration
Hypostatic Pneumonia	2-3 days.
Due to Acute Cardiac	10 days.
Due to DE compensation	
Other conditions Diabetes Mel chronic suppurative (Include pregnancy within 3 months of death)	unknown.

Major findings:
Of operations none
Of autopsy none

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide ✓
(b) Date of occurrence ✓
(c) Where did injury occur? ✓ (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? ✓ (Specify type of place) While at work? ✓
(e) Means of injury ✓

23. Signature W. A. Wimsatt M.D. M. D. or other
Address 11-1016-16th St. N.W. Date signed 5/16/40
WASH., D.C.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (94a)

Reg. Dist. No. 216

05592

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Montgomery Ct.

(b) City or town Chevy Chase.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 103 E. Underwood St.

(d) Length of stay in hospital or inst. (yrs., mos., or days) —

(e) Length of stay in this community (yrs., mos., or days) 20 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Montgomery

(c) City or town Chevy Chase
(If outside city or town limits, write RURAL and give town)

(d) Street No. 103 E. Underwood
(If rural give location)

(e) If foreign born, how long in U. S. A.? 40 years

3 (a) FULL NAME Ethel Blanche Percival.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex F

5. Color or race W.

6 (a) Single, married, widowed, or divorced. Single.

6 (b) Name of husband or wife —

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 6 '69

8. AGE: Years 70 | Months 5 | Days 18 | If less than one day ____ hr. ____ min.

9. Birthplace Basseterre, St Kitts. B.W.I.
(Town, county, and state)

10. Usual occupation none.

11. Industry or business

FATHER
12. Name William Percival
13. Birthplace West Indies

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Niece
(b) Address 103 Underwood St. Ch. Ch. Md.

17 (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-24-40 (month) (day) (year)

(c) Cemetery or crematory Rock Creek

Location Washington D.C.

18 (a) Funeral director Martin J. Hyson

(b) Address 1300 N. St. Washington

19 (a) May 24th 1940 (Date rec'd by registrar) (b) B. C. Perry. M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 24 1940, at 10 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1923, to May 1940, and that I last saw him alive on May 24 1940

Immediate cause of death	Duration
Coronary Sclerosis	6 mo.
Due to Essential Hypertension	10 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Truman Abbe
M. D. or other

Address 3741 Huntington St. Chevy Chase D.C. Date signed 5/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 4 1940
[illegible] V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

05593

CERTIFICATE OF DEATH

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montg, Co

City or town: Rockville Md (City)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 8 Mo

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Montg

City or town: Rockville Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Robert Eugene Phillips

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife: U U

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 1st, 1934

8. AGE: Years	Months	Days	If less than one day
1934 5	8	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Zeph Phillips
13. Birthplace: Flo,

MOTHER
14. Maiden name: Barbra Faul
15. Birthplace: Penna

16. Informant: Zeph Phillips
Address: Rockville Md

17. (Burial, cremation, or removal. Which?): Burial Date thereof: 5/12/40 (month) (day) (year)

Cemetery or crematory: Neelsville Md

Location: Near Germantown Md

18. Funeral director: Ernest C Gartner

Address: Gaithersburg Md

19. 5.10.1940 (Date rec'd by registrar) Faye Barnsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9th 1940, 19, at 2.05 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1940, to May 9 1940; and that I last saw alive on May 9 1940.

Immediate cause of death	DURATION
Acute Lymphatic Leukemia	3 months
Due to	
Due to	
Other conditions: Recent Scarlet fever	Feb, 1940.

(Include pregnancy within 3 months of death)

Major findings:

Dt operations: none

Dt autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm A. Smithwood, M.D.
M. D. or other

Address: Rockville, Md Date signed 5/10/40

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(170-C)

05594

Reg. Dist. No. 217

1. PLACE OF DEATH:
County Montgomery
City or town Olney, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: The Montg. Co. Gen'l Hospital
Stay in hospital or inst. (yrs., or mos., or days) 1
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Brookeville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R. F. D. #1 - Md.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William H. Powell

3. (b) Social Security Number none

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Married
B (b) Name of husband or wife: Pearl Powell
B (c) If alive, give age 60 years
7. Birth date of deceased (mo., day, yr.): Feb. 11, 1870

8. AGE: Years 70 | Months 3 | Days 10 | If less than one day ___ hrs. ___ min.

9. Birthplace: Chappell Hill, Tennessee (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Farm

FATHER
12. Name: Austin Powell
13. Birthplace: Kentucky

MOTHER
14. Maiden name: Blackwell
15. Birthplace: Tennessee

16. Informant: Hospital Records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23-1940 (month) (day) (year)
Cemetery or crematory: Brookeville Md
Location: Montgomery Co Md
18. Funeral director: Roy W. Barber
Address: Laytonsville Md

19. May 22 1940 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21st 1940, at 9:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19__, to 19__, and that I last saw h__ alive on 19__.

Immediate cause of death: Coroner Case
Probably fracture
Due to: Skull hemorrhage
Due to: Shock

Other conditions: Hy. Pertension
Laceration forehead fracture of
(Include pregnancy within 3 months of death)
Major findings of operation: Right Clavicle Laceration
Left leg & right arm
Of autopsy

DURATION
f
f

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 5/20/40
Where did injury occur? Near Ellicott Lawrence Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Auto accident Injured at work? no

23. SIGNATURE C. E. Hawks M. D. or other
Deputy Med. Ex. of Mont. Co. Md
Address C. E. Hawks Date signed 5/21/40
Rockville Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

05595

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Silver Spring Md.
(If outside city or town limits, write RURAL, NEAR and give town)
Street address, hospital, or institution: Linden
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Silver Spring Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Linden
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas Warfield Schaeffer

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Julia Murray Schaeffer
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 13 1864

8. AGE: Years	Months	Days	If less than one day
1864 75	9	11	hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Retired Hammer —
11. Industry or business
FATHER 12. Name William C. Schaeffer
13. Birthplace Mich.
MOTHER 14. Maiden name Emily Gallion
15. Birthplace Md.
16. Informant Mrs Jay Hall
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26/40 (month) (day) (year)
Cemetery or crematory Fairfax
Location Fairfax Va
18. Funeral director Ernest C. Gaither
Address Gaithersburg Md.
19. May 25 1940 (Date rec'd by registrar) Hallie B. Lisby Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1940, at 4:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 24th 1939, to May 24th 1940, and that I last saw him alive on May 23rd 1940.

Immediate cause of death	DURATION
Lymphatic Leukemia	?
Due to	
Due to	
Other conditions Chronic Myocarditis	?

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Marion Bankhead M.D.
M. D. or other
Address Silver Spring Date signed 5/24/40

RECEIVED
JUN 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

05596

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

WITHIN CORPORATE LIMITS OF

City or town Takoma Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Sanitorium & Hospital

Stay in hospital or inst. (yrs., or mos., or days) 23 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Hyattsville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 920 West Madison Avenue

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Hattie A. Schindel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Harry E. Schindel

6(c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.) December 21, 1874

8. AGE: Years	Months	Days	If less than one day
65	4	23	hrs. min.

9. Birthplace Montgomery County, Md.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name George W. Mathers

13. Birthplace ? Virginia

MOTHER 14. Maiden name Caroline Hall

15. Birthplace ? Maryland

16. Informant Washington Sanitorium & Hospital Records

Address Takoma Park, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 16, 1940 (month) (day) (year)

Cemetery or crematory Hyattsville Md

Location Hyattsville Md

18. Funeral director F Gaschs sons

Address Hyattsville Md

19. May 16, 1940 (Date rec'd by registrar) J. H. Dudley Registrar Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1940, 11 16 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 22 1940, to May 15 1940, and that I last saw her alive on May 15 1940.

	DURATION
Immediate cause of death: Myocardial Heart failure	10 days
Due to: obstructed bowel	3 wks
Due to: Strangulated Umbilical Hernia	3 wks.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: Of operations: Strangulated Hernia

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wendell E. Malin M.D. M. D. or other

Address Riverdale Md. Date signed 5/15/40

RECEIVED
JUN 5 1940
BUREAU V. S.

05597

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(937)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Martha B. Sheffler.

3. (b) Social Security Number none

4. Sex: Female

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2, 1884.

8. AGE: Years: 56 Months: 11 Days: 6 If less than one day ..... hrs. ..... min.

8. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Gen. Housework

11. Industry or business

FATHER

12. Name: Charles Derrichs.

13. Birthplace: Baltimore, Md

MOTHER

14. Maiden name: Burnie Parker

15. Birthplace: Baltimore, Md.

16. Informant: Mildred Sheffler

Address: Rockville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 12, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Oliva

Location: Frederick Co. Md.

18. Funeral director: Robert L. Snowden

Address: Rockville, Md

19. May 11th 1940 (Date rec'd by registrar) B. C. Perry, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1940 at 11.04 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Comes Case 19..., to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute dilatation of heart due to Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. E. Hawks M.D. M. D. or other

Address: Rockville Md Date signed: 5/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05598

Reg. Dist. No. 217

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Olney Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: The Montg. Co. Genl Hospital
Stay in hospital or inst. (yrs., or mos., or days) 43 days
Stay in this community (yrs., or mos., or days) 43 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Gaithersburg Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lottie Shreve

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6 (b) Name of husband or wife Robert N. Shreve
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 23, 1893

8. AGE:

Years	Months	Days	If less than one day
46	11	1	hrs. min.

9. Birthplace Charles County, Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Home
FATHER 12. Name Andrew Laurence
13. Birthplace Australia
MOTHER 14. Maiden name Mary Shoemaker
15. Birthplace Charles Co. Md.
16. Informant Hospital Records.
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25 1940 (month) (day) (year)
Cemetery or crematory Leytonsville Md
Location Montgom Co Md
18. Funeral director Roy W. Barber
Address Leytonsville Md
19. May 24 1940 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 1940, to May 24 1940, and that I last saw her alive on May 24 1940

	DURATION
Immediate cause of death Tumor Spinal	2
Due to Sarcoma	1
Due to Myocarditis Acute	2 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. W. Bi
M. D. or other
Address Sandy Spring, Md. Date signed

RECEIVED
JUN 6 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

05599

Reg. Dist. No. 214

1. PLACE OF DEATH:
County Montgomery
City or town outside Kensington
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
39 Decatur St.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 20 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town outside Kensington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 39 Decatur St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Minnie Hardin Simpson

3. (b) Social Security Number none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
female	white	widowed

6 (b) Name of husband or wife James W. Simpson
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 3, 1857

8. AGE: Years	Months	Days	If less than one day
83	1	20	____ hrs. ____ min.

9. Birthplace Muncie, Indiana (Town, county, and state)
10. Usual occupation none
11. Industry or business —

FATHER
12. Name Franklin Alan
13. Birthplace Dublin, Ohio

MOTHER
14. Maiden name Alice Barnes
15. Birthplace unknown

16. Informant Mrs. Eleanor Ames
Address 39 Decatur St., Kensington

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5/12/40 (month) (day) (year)
Cemetery or crematory Rockville Union
Location Rockville, Md.
18. Funeral director Mr. Reuben Pumphrey
Address 7005 Wis. Ave. Bethesda Md.

19. May 12 1940 (Date rec'd by registrar) Margaret C. Tremearne Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, at 7 02/4 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1927, to May 10 1940
and that I last saw her alive on May 9 1940

Immediate cause of death	DURATION
Uremia	2 mos
Due to Apoplexy	2 yrs
Due to Cardio-vascular-renal disease	13 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Katharine A. Chapman M.D.
M. D. or other
Address 208 W. Bath St., Kensington Date signed 5/10/40.

RECEIVED
JUN 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05600

Reg. Dist. No. 214

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 9206 - Woodland Road

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 4 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Montgomery County:

City or town: Silver Spring Ward No.:

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 9206 Woodland Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Anna ~~Hunt~~ Lawrence Strother

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) single, married, widowed, or divorced
Female	White	Separated

6 (b) Name of husband or wife: Hunt Strother

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 14, 1882

8. AGE: Years	Months	Days	If less than one day
58	2	12	hrs. min.

9. Birthplace: Lake City Minn.

(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Y. W. C. A.

FATHER 12. Name: Frank Coons

13. Birthplace: Culpepper Va.

MOTHER 14. Maiden name: Jean Erskine

15. Birthplace: St Louis Mo.

16. Informant: Mary Coons Bickus

Address: 9206 Woodland Rd.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 5-27-40 (month) (day) (year)

Cemetery or crematory: Cedar Hill Cremetorium

Location: Suitland Md.

18. Funeral director: Jos Gawler's Sons

Address: 1756 Pa Ave N.W. Wash D C

19. May 26 1940 (Date rec'd by registrar) Sallie B. Leching Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1940, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1930, to above date, and that I last saw her alive on May 23 1940.

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Hypotension	
Due to Extensive Varicosities	
Other conditions Secondary Anemia	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Grace G. Furse M.D.

M. D. or other

Address: 1801 - Eye St N.W. Washington D.C.

Date signed: May 26 1940

RECEIVED
JUN 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

05601

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

WITHIN CORPORATE LIMITS OF

City or town: Takoma Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Sanitarium and Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Bethesda Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 2151 Georgetown Road

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Baby Boy Sullivan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1940 6 36 pm

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Takoma Park, Montgomery Co., Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER

12. Name: George Brooks Sullivan

13. Birthplace: Brookville, Md.

MOTHER

14. Maiden name: Ruth Armfield

15. Birthplace: New Bedford, Mass.

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/3/40 (month) (day) (year)

Cemetery or crematory: Rockville Cem.

Location: Rockville

18. Funeral director: Ernest L. Gaither

Address: Jacksonemer, Md.

19. May 2 1940 (Date rec'd by registrar) J. Wilkin Revell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 1940, at 6:36 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from still-birth 19, to 19,

and that I last saw h alive on 19.

Immediate cause of death	DURATION
intrauterine asphyxia	
Due to same unknown	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: at delivery lungs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Emma Hughes M.D.

M. D. or other

Address: Takoma Park, Md. Date signed 5-2-40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-e)

05602

CERTIFICATE OF DEATH

Reg. Diat. No. 2-17

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Olney
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
The Montgomery County General Hospital Inc.

Stay in hospital or inst. (yrs., or mos., or days) 2 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Sellman Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Thomas.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single.

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 23, 1940

8. AGE: Years | Months | Days: 14 | If less than one day: ____ hrs. ____ min.

9. Birthplace Sellman, Montgomery Co. Md.
(Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER
12. Name Carroll Thomas.
13. Birthplace Martinsburg, Md.

MOTHER
14. Maiden name Fanny School
15. Birthplace Va.

16. Informant Hospital Records.
Address

17. Burial Date thereof May 8, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Martinsburg

Location Mt. Pooleville, Md.

18. Funeral director Billy Hilton

Address Barnesville, Md.

19. May 8 1940 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1940, at 7 20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1940, to May 7 1940, and that I last saw him alive on May 7 1940.

Immediate cause of death	DURATION
Intestinal Intussusception	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. or other

Address Sandy Spring, Md. Date signed 5/7/40

Billy Hilton

Martinsburg

Martinsburg W. Va.

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JUN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05603

37-a

1. PLACE OF DEATH

County Montgomery Registration Dist. No. 213

Village or City Rockville No. Chestnut Lodge Sanitarium St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. 2 ds. How long in U. S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Mary R. Tremblay If U. S. Veteran, specify WAR

(a) Residence: No. Stafford Court House Ward. 3 (b) S.S. (None)

(Usual place of abode) Virginia

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of None

6. DATE OF BIRTH (month, day, and year) September 8, 1916

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
23	8	0	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Maid

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 2 wks ago

11. Total time (years) spent in this occupation 6 yrs.

12. BIRTHPLACE (city or town) (State or country) Washington, D. C.

FATHER

13. NAME Howard R. Tremblay

14. BIRTHPLACE (city or town) (State or country) Austin Pennsylvania

MOTHER

15. MAIDEN NAME Lydia Shilton

16. BIRTHPLACE (city or town) (State or country) Stafford Virginia

17. INFORMANT Howard R. Tremblay (Address) Stafford, Virginia

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Stafford, Virginia Date May 12, 1940

19. UNDERTAKER Wm. Reuben Pumphrey (Address) 7005 Wisconsin Ave., Bethesda, Md.

20. FILED 5-9, 1940 Faye Barnsley Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 8 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 6, 1940, to May 8, 1940

I last saw her alive on May 8, 1940; death is said to have occurred on the date stated above, at 2:22p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Lobar Pneumonia	May 6

Other Contributory Causes of importance:

Encephalitis (Epidemic)

Name of operation ___ Date of ___

What test confirmed diagnosis? Clinical & laboratory & autopsy Was there an autopsy? yes

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of Injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ___

(Signed) Douglas Noble M. D.

(Address) Rockville, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE [redacted], WITH UNFADING INK—THIS IS A PERMANENT REC[redacted]ery item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The **principal cause of death** and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (72-d)

CERTIFICATE OF DEATH

05604

Reg. Dist. No. 211

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Lewisdale
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montg.
City or town: Lewisdale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sarah Elizabeth Tucker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F.	W	Widowed

B (b) Name of husband or wife: Charles Wesley Tucker
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 3, 1859

8. AGE:

Years	Months	Days	If less than one day
80	7	3	hrs. min.

9. Birthplace: Howard Co. Md
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: George Washington Grimes
13. Birthplace: Howard Co. Md.

MOTHER
14. Maiden name: Louisa Snyder
15. Birthplace: Howard Co. Md

18. Informant: Mrs Windsor Beall
Address: R.D. Monrovia, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1940 (month) (day) (year)
Cemetery or crematory: St Johns
Location: Ellicott City Md

18. Funeral director: F. C. Higinbothom Jr
Address: Ellicott City, Md.

19. May 7 1940 (Date rec'd by registrar) Della N. Burdette Dep't. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1940, at 2P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 6 1940, and that I last saw her alive on May 5 1940.

Immediate cause of death	DURATION
Thrombosis - brain	5 days
Due to Hypotension	1 yr
Due to	
Other conditions Chronic Endocarditis	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George M. Boyer M.D.
M. D. or other
Address: Damascus, Md Date signed: 5-7-40

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-c)

05605

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Buck Lodge Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.

City or town Buck Lodge Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME Bettie Lou Turner

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Negro	Infant

6 (b) Name of husband or wife —

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 9, 1940

8. AGE: Years — Months — Days — If less than one day 2 hrs. — min.

9. Birthplace Buck Lodge Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Preston Davis Turner

FATHER 13. Birthplace Buck Lodge

MOTHER 14. Maiden name Mary Beatrice Campbell

MOTHER 15. Birthplace Buck Lodge

16. Informant Preston Davis Turner

Address RFD Boyds

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10-40 (month) (day) (year)

Cemetery or crematory Senders

Location Boyds Md

18. Funeral director By Fisher (Preston Turner)

Address RFD Boyds Md

19. May 14 1940 (Date rec'd by registrar) Mrs. C. C. Hilton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~from~~ at birth May 9 - 9 A.M. 1940, to time of death at 11 P.M. and that I last saw her alive on May 9, 1940 ~~25~~

Immediate cause of death	DURATION
Asphyxia neonatorum	2 hours
Due to Prolapsus funis	
Due to Breech presentation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Geo. D. Selby, M.D. M. D. or other

Address Dawsonville, Md. Date signed 5-10-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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JUN 6 1940
BUREAU OF S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

05606

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

WITHIN CORPORATE LIMITS OF

City or town Takoma Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Wash San & Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County Pr. Geo.

City or town Berwyn Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Unnamed female infant Walker

3. (b) Social Security Number

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 10 - 1940 6 35 P.M

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Edwin Walker

13. Birthplace Berwyn, Md.

MOTHER

14. Maiden name Catherine Snydeman

15. Birthplace Harrisburg, Penna

16. Informant Wash. San. & Hosp. Records

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 - 11 - 1940 (month) (day) (year)

Cemetery or crematory Nat'l Cap. Mem. Park Cemetery

Location Laurel, Md.

18. Funeral director F. Fasch's Sons

Address Hyattsville, Md.

19. May 11 1940 (Date rec'd by registrar) J. Wilson Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 - 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18, to 19, and that I last saw h alive on Stillborn. 19

Immediate cause of death accident of pregnancy

Due to

Due to

Other conditions pre-eclamptic toxemia

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D. M. D. or other

Address Takoma Park Date signed 5-10-40

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JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-C)

056117

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Montgomery
City or town Potomac
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Potomac. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Julia Nannette Williams

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Arthur Williams.
Dec. 5th 1892 6(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec 5, 1892

8. AGE: Years	Months	Days	If less than one day
47	5	26	hrs. min.

9. Birthplace Dickenson, Montgomery, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Laurence Allnutt White
13. Birthplace Dickenson, Maryland

MOTHER
14. Maiden name Annie Oliver Belt
15. Birthplace Dickenson, Maryland

16. Informant Mrs Annie Everett, Sister
Address Dickenson, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4 1940 (month) (day) (year)
Cemetery or crematory Monocacy Cemetery
Location Braddock Md.
18. Funeral director Warner E. Dunphrey
Address Rockville, Md.
19. May 4 19 40 Faye Barnsley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1940, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938, to May 1 1940, and that I last saw her alive on May 1 1940.

Immediate cause of death	DURATION
Metastatic Adeno carcinoma.	4 Months
Due to Adeno Carcinoma Vagina.	4 months
Due to Adeno Carcinoma Uterus	2 years ±
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Adeno carcinoma. Hysterectomy July 1938
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William W. Weld. M. D. or other
Address Rockville Date signed 6/2/40

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JUN 4 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(159)

05608

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Montgomery

WITHIN CORPORATE LIMITS OF

City or town Takoma Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Washington Sanitarium & Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montg.

City or town Takoma Park Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 9 New Hampshire Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Geraldine Eloise Unnamed infant (girl) Winegar

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May - 11 - 1940

8. AGE: Years | Months | Days | If less than one day 16 hrs. 15 min.

9. Birthplace Takoma Park, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Charles Joseph Winegar
13. Birthplace Whitestone, Va.

MOTHER
14. Maiden name Belma Winsboro
15. Birthplace Front Royal, Va.

16. Informant Washington San. & Hospital Records

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13, 1940 (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cemetery

Location Bladensburg, Md.

18. Funeral director J. Arthur Dallers

Address 254 Carroll St., Takoma Park, D.C.

19. May 13th 1940 (Date rec'd by registrar) J. Hilton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 - 1940, at 10 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 11 1940, to May 12 1940, and that I last saw ER alive on May 12 1940

Immediate cause of death Cardiac decompensation (7 months premature)

Due to Triplets

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy No

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. A. Shannon M.D. M. D. or other

Address 113 Carroll St. N.W. Date signed

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

05605

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

Reg. Dist. No. 212

1. PLACE OF DEATH:

County Montgomery

City or town Rural Near Seneca Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Seneca ~~R.F.D.~~ Poolesville Md

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) Parents Resided in Montg Co. for 14 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rural Near Seneca Md Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. R.F.D. Poolesville Md (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Rosa Mabel Wolfrey (Premature still born infant 7 mo gestation)

3. (b) Social Security Number —

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced —

6 (b) Name of husband or wife —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 18th 1940

8. AGE: Years 0 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Rural Near Seneca Montg Co Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Richard D. Wolfrey.

13. Birthplace Orange Co. Va

MOTHER 14. Maiden name Mary Ella Byram.

15. Birthplace Orange Co Va.

16. Informant Richard D. Wolfrey.

Address R.F.D Poolesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 18 1940 (month) (day) (year)

Cemetery or crematory Premise of Parents on property of W. R. Tomlinson

Location 3 miles west of Seneca Md.

18. Funeral director Parents

Address Seneca Md

19. May 18 1940 (Date rec'd by registrar) E W White Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16th 1940, at 5:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from at Still birth May 18 1940, and that I last saw h — alive on — 19

Immediate cause of death Not determinable Called in night to attend this delivery. History of no viability for 48 hrs before birth

Due to Premature birth at 7 mo gestation

Other conditions Had no prenatal care (negligence of parents) (Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE Upton D Nourse M.D. M. D. or other

Address Dawsonville Md Date signed 5/18/40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

05610

Reg. Dist. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 11 Laird St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Rockville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 11 Laird St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR NO

3. (a) FULL NAME Naomi Bogley Young.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William M. Young

6.(c) If alive, give age about 50 years

7. Birth date of deceased (mo., day, yr.) February 13 - 1893

8. AGE: Years	Months	Days	If less than one day
47	3	13	hrs. min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own Home

FATHER 12. Name James T. Bogley

FATHER 13. Birthplace Mouly Co- Maryland

MOTHER 14. Maiden name Cora Lee Beckham

MOTHER 15. Birthplace Virginia

18. Informant Mr. Wm. M. Young (Husband)

Address 11 Laird St - Rockville - Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28-1940 (month) (day) (year)

Cemetery or crematory Rock Creek

Location Washington D.C.

18. Funeral director Wm. Reuben Dumphrey

Address Rockville - Maryland

19. 5-27 (Date rec'd by registrar) 1940 Faye Barnsley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1940, at 6:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938, to May 25 1940.

and that I last saw h CR alive on May 23, 1940 1940

Immediate cause of death	DURATION
Metastatic Carcinoma.	1 year
Due to Carcinoma Breast	5 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations Carcinoma Breast (1935)

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William M. Webb M. D. or other

Address Rockville, Md. Date signed 5/25/40.

RECEIVED
JUN 4 1940
BUREAU F. S.